APPRAISALS OF EXPERIENCE IN FEE-FOR-SERVICE GROUP PRACTICE IN A SUBURBAN COMMUNITY*

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I AM one of eight internists in a 20-year-old service group which now consists of 21 board-certified members and is situated next door to a community hospital of 212 beds and a medical staff of 137.

We are convinced that our viability and continuation of high standards of practice depend primarily on the careful selection of new members. No new men have been accepted without repeated interviews with all the partners, without comparison with other candidates, and without, where possible, verbal confirmation and amplification of written references. We have resisted the temptation to settle for someone about whom there were reservations, even though the need was great and we had to continue our search for a disconcertingly long time. Choice is difficult not because of a paucity of well-trained and potentially competent candidates, but because of uncertainties about the applicant's adaptability to the ways of group practice. Submission to the will of the majority, sensitivity for the feelings of his associates, and a degree of conformity are essential qualities in a group member.

In 20 years four men have left in order to go into hospital practice or to retire. No one has been requested to leave.

Lest it be assumed that a period of trial would obviate this painstaking scrutiny, may I say that once a physician has established close relations with patients his withdrawal would be disappointing for those patients who had come to rely on him, and it would suggest to them that future recruits might also withdraw. A new physician might therefore be unacceptable to them because of this uncertainty. Further, thoughtful and desirable candidates would shy away from an opportunity unless a reasonable assurance of permanence were provided. The most gratifying result of careful selection of one's associates has been

*Presented in a panel, Appraisals of Experience in Fee-for-Service Group Practice, as part of the 1968 Health Conference of The New York Academy of Medicine, *Group Practice: Problems and Perspectives,* held at the Academy, April 25 and 26, 1968.

the compatibility that has existed throughout the group's history. Personality conflicts have been few and reconcilable. Our group is a democratic partnership without domination by any specialty, individual, or vested interest. Annually since our inception we have elected a chairman, who may be reelected for a maximum period of three years; he appoints standing committees as he sees fit. There is no executive committee, which could expedite matters but would usurp the individual partner's prerogatives and responsibilities in moulding the ideals, growth, and conduct of the practice. Regular weekly meetings permit airing of disagreements and criticisms and they also bring colorful opinions to bear on matters that might otherwise seem black or white. Needless to say, physicians have more than their share of opinions on all matters, and meetings sometimes appear to be filibusters. There is no doubt that interdepartmental understanding and cooperation are strengthened by regular formal meetings. There have been times when prolonged night meetings were necessary in order to discuss and decide on building and fiscal matters. Attendance has been good, considering the inevitable conflicts of busy practice. A simple majority decision is final unless a partner requests a two-thirds majority because of the importance of the matter. Unanimity is necessary for the election of an associate to partnership after his initial two years with the group.

The original partnership of five physicians stipulated that net income be shared equally. Partly because of discrepancies in earnings between the surgical specialties and medicine and pediatrics, and partly because the tradition that surgical specialists command a higher income is a fact of life, we engaged in a long period of discussion, cost accounting, and trial of various complicated differentials between surgeons and nonsurgeons. Ultimately, five years ago, 12 per cent of a partner's share was added to that of each surgeon, orthopedist, and obstetrician. This has been a satisfactory solution; at least there have been no suggestions to alter or abandon it.

The growth of our practice has made work enough to justify the presence of at least two physicians in each department: pediatrics, medicine, surgery, orthopedics, and obstetrics and gynecology. A single man attached to a department for any length of time has no one to relieve him, to share his puzzlements with, or give him new ideas. He is deprived of many of the professional advantages of group practice.

We obtained a business manager full-time when our group num-

bered seven men. His function has naturally become more complex and important with our growth and with the increasing paper work of third-party payments, government tax forms, and quarterly reports to the group on its financial status. We rely heavily on his fiscal judgment and management of accounts. Here again the harmony of the group depends in no small measure on the personality, integrity, and tact of the manager.

The quality of the Unit Patient Chart serves not only as a criterion by which to judge the caliber of medical care but also as an example for new men. The chart is a constant reminder that this evidence of a physician's work will inevitably be used and, in the process, judged by other physicians in the group as they are called on to care for the patient. Comments and criticisms, both casual and deliberate, are frequent enough to remind us all that, to an extent, we practice in a glass house.

We have not found it worth while to keep a diagnostic file. No one in the group has been anxious to publish.

Persons who have not been patients of the group and also physicians outside the group are prone to say that group practice is more impersonal than solo practice. I see no evidence to support this judgment. Our physicians are as jealous of their patients as they would be in solo practice. It is only when the requested physician is unable to see his patient within the desired time that another physician is proffered. If this happened more than once and a different substitution occurred each time, it would be true that the patient "saw a different doctor on each visit." This can occur in any type of practice. In our practice the substitute physician continues as such until the physician of record is again available for continuation of care. Patients do make changes on their own initiative or inertia. This is not discouraged, although the patient may be asked by the next physician if the change is deliberate or just expedient. The deliberate transfer of a patient to another physician in the same department without consultation is not countenanced. Although many a patient comes to the group without having chosen a particular physician, we assume that he desires a personal physician. Where applicable, our procedure has been to offer such a patient the newest man in a department, as is done with any new patient who requests a physician who is too busy or absent. Internists and pediatricians have had an abbreviated roster of men on duty *only* on Saturday afternoons,

Sundays, and the main holidays. They have not, so far, had a rotating schedule of duty at night and do not relegate the care of acutely ill people to others except when, for good reason, they will be unavailable. With a four-to-six weeks' vacation a year, depending on age and department, and on the opportunity to sign off to an associate when desired, the private life of the group physician has been comfortable. One of the unsolved problems of a "share-and-share-alike" partnership is that of establishing a balance between a comfortable and gratifying work load and earnings. An individual who requires greater income than he derives from the group cannot obtain it by his effort alone. He can press the group as a whole to work harder, raise its fees, or economize. Similarly if a man is not in need and does not want to be pressed, in fairness to his associates he cannot slow down without officially changing his status as a partner. As the latter problem has not arisen, we have not tried to solve it without particulars as to age, specialty, and desires of the partner.

Another problem which we have decided to let solve itself is that of the ultimate size of our group. We have prevented overloading a department with work by taking on a new man. The alternative would be to turn away new patients in that department until the pressure eased, but this might cause detrimental slack in another department through decrease in referrals.

Every man is encouraged to obtain a teaching appointment. With some this has involved as much as six half days a week for two months a year. The difficulty of our suburban area is that of obtaining desirable teaching duties which, with travel, do not overburden an already busy physician. The members are also permitted a week each year for attending educational sessions. In view of the professional satisfaction that derives from practicing in them, it is difficult to understand the slow birth of service groups throughout the country. I must point out that the type of service we give depends for its support on a medically sophisticated clientele which has above-average income. About 3 per cent of our gross income is derived from Medicaid at the present time. Medicaid patients previously were not being charged or were not paying as much as Medicaid now pays us.

We also depend on the presence in the community of excellent specialists in fields which have no representation in our group and in which we could not furnish sufficient work or income to warrant the

enrollment of a specialist. As we are in competition with solo practitioners and with another service group of eight men, and as we have no specialist not matched by similar ones in the community, we receive little referral work.

In summary, our group believes that careful choice of members is the most important prerequisite of a successful group, that good medicine requires good medical records, that a democratic partnership is the best organization for a service group, that service-group practice in our area is successful and desirable for both patient and physician. It is hard to find fault with the system I have described.